RESOURCE AND PATIENT MANAGEMENT SYSTEM

EHR & Meaningful Use for Health Information Management Professionals

Announcement and Agenda

June 18 - 22, 2012

Office of Information Technology (OIT)
Albuquerque, New Mexico
and
Cherokee Nation Health Services, Oklahoma City Area Office,
Portland Area Office, Phoenix Area Office,
Nashville Area Office, Bemidji Area Office, Aberdeen Area Office (Sioux
Falls), Billings Area Office, Tucson Area Office, California Area Office,
Alaska Area Office – ANTHC, Navajo Area Office (Gallup)

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1.0   General Information

1.1   Purpose of Training

The Resource and Patient Management System Electronic Health Record (RPMS EHR) is a suite of software applications that moves a facility from a paper to Electronic Health Record technology for the purpose of meeting Meaningful Use (MU) to improve patient care. Medicare and Medicaid EHR Incentive Programs provide a financial incentive for the "Meaningful Use" of certified EHR technology to achieve health and efficiency goals

The purpose of this intense hands-on course is to provide Health Information Management (HIM) professionals with an understanding of:

- Requirements and expectations of Meaningful Use as it applies to HIM roles and responsibilities.

- Policy, objectives, staff responsibilities, and standards relating to health record services as it pertains to electronic health information.

The "need" for this course was determined from (a) the need for an understanding of Meaningful Use and HIM reports, requirements, and maintenance; (b) requests from sites and Area Health Information Management (HIM) Consultants; (c) Area Clinical Application Coordinator (CAC) and HIM meetings; and (d) Meaningful Use deployment plan.

1.2   Prerequisites

This intense one week hands-on class is designed for HIM professionals including but not limited to RHIA, RHIT, Certified Coders (CPC, CCS, CCS-P, CPC-H, CPC-I, CCA, etc.) and other Health Information personnel who provide ongoing support for health care providers participating in the Meaningful Use incentive program. The class is also for HIM professionals who have oversight of RPMS packages associated with the Certified Electronic Health Record including the RPMS EHR, Health Information Exchange (HIE), Personal Health Records (PHR), Meaningful Use reports, and others.

Knowledge, skills, and competencies required for this course include cognitive knowledge and competent utilization to include:

- Understanding the RPMS PCC and EHR architecture

- Delineating the expectations, roles, and responsibilities of HIM professionals concerning issues that surround the Certified RPMS EHR and Meaningful Use

- Experience navigating through RPMS EHR and its tabs

- Experience or training navigating through RPMS PCC Data Entry fields and use of PCC mnemonics

- Experience with running reports for maintaining a complete and accurate medical record

1.3   Guidelines for Receiving Continuing Education Credit

Index# IHS1019111058A

This program meets AAPC guidelines for 12.0 CEUs in Core B.

Please note: Core B can comprise more than 33% (1/3) of the total Core continuing education units.

*This program has the prior approval of AAPC for continuing education hours. Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.

The education planning committee has put together an extraordinary program for Health Information Management (HIM) Professionals. To receive a certificate of continuing education, you must (a) attend the educational even in its entirety, (b) document your attendance on the sign-in sheet and (c) successfully complete an on-line evaluation at the end of the course. Survey Monkey(R) will be used to evaluate presenters and the overall training. Continuing Education will only be awarded to those participants that have completed the entire course. There will be no partial credit.

Wednesday, October 19, 2011

Deanna Dennis
Indian Health Services
PO Box 366600 Billings, MT 59107

Dear Deanna Dennis,

We are in receipt of your application and request for Continuing Education Units (CEUs) awarded by AAPC for the Workshop entitled 'EHR -MU for Health Information Management ', sponsored by Indian Health Services. After reviewing your application, we find this program or product to contain worthy educational information pertaining to the coding profession, and as such, we hereby approve your request as follows:

1. 12.0 CEU(s) will be awarded to 'individuals' receiving your Workshop, index # IHS1019111058A. The terms of this agreement apply only to the aforementioned Workshop. An index number may be submitted for CEU credit one time only.

2. 12.0 CEU(s) will be awarded to the 'presenter' receiving your Workshop, index # IHS1019111058A for the 'first presentation only'. The terms of this agreement apply only to the aforementioned Workshop. An index number may be submitted one time only. A presenter may submit up to 16 CEUs earned as a presenter during a two year submission period.

CEUs previously approved in 2009 and 2010 will be honored. CEU guidelines apply to the year in which the CEUs are earned, not submitted.

This agreement shall remain in force until 12/31/2012. Following the expiration date, no CEUs will be honored. To reapply, simply repeat the application process by submitting a new application along with all required information.

As a part of the approval process, your organization and above-mentioned approved Workshop will be listed on the official AAPC CEU Vendor List for the duration of this agreement. To view this information on the pre-approved vendor list, please visit our Web site at www.aapc.com/medical-coding-education/vendors/index.aspx If you do not seek reapproval for CEU credits, the above stated program or product will be removed from the list of pre-approved CEU Vendors on the expiration date.

Enclosed is a Certificate of Approval for your use with, 'EHR -MU for Health Information Management '. In an effort to standardize certificates, AAPC requires vendors to provide each attendee a copy of the original PDF certificate provided by AAPC. The approved AAPC certificate cannot be

changed in any way other than to add the name of the attendee, the event date, or an index number when one is not recorded.

It is acceptable for you to make a personalized certificate for your events. It is not permissible to use the AAPC index number, CEU value, the AAPC logo, or the statement of approval on your personalized certificate. Remember, even if you distribute a personalized certificate, you must also provide the attendee with a copy of the original PDF certificate provided to you by AAPC. If requested by AAPC for verification purposes, each attendee is responsible for submitting a copy of the original PDF certificate at their time of membership renewal to receive CEU credit for attending.

AAPC has a new CEU Approved Logo! The CEU Approved vendor logos are for approved CEU vendors only and have been removed from the general Web site. AAPC invites you to visit www.aapc.com/ceumarketing to access the prepared logo and text to be displayed when marketing your CEU approved status. As part of the approval process, AAPC randomly and routinely audits marketing of CEU approvals. Feel free to contact me if you have any questions regarding marketing of your product within AAPC guidelines.

If you would like to consider offering your continuing education programs or products to a national audience, there is no better way than through advertising with AAPC. For more information on advertising visit our Web site https://www.aapc.com/advertise/website-advertising.aspx; or you may contact the Marketing and Advertising Coordinator, at 800-626-2633 ext 191.

Thank you for your interest and support of AAPC and our continuing education programs. If you have any questions or concerns please feel free to call me at 800-626-2633 ext. 115. I'm always happy to talk with you.

Cordially,

Shelly Cronin, CPC, CPMA, CANPC, CGSC, CGIC
Department Head, CEU Vendor Relations
AAPC

www.aapc.com
Credentialing the Business Side of Medicine

2.0   Learning Objectives

See Detailed Agenda (Section 4.0).

3.0   Instructors and Facilitators

Disclosure Statement: In order to ensure balance, independence, objectivity, and scientific rigor in its educational activities, the (a) course directors/coordinators, (b) planning committee members, (c) faculty, and (d) all others who are in a position to control the content of this educational activity are required to disclose all relevant financial relationships with any commercial interest related to the subject matter of the educational activity. Safeguards against commercial bias have been put in place. Faculty will also disclose any off-label and/or investigational use of pharmaceuticals or instruments discussed in their presentation. The course directors/coordinators, planning committee members, and faculty for this activity have completed the disclosure process and have indicated that they do not have any significant financial relationships or affiliations with any manufacturers or commercial products to disclose.

3.1   Albuquerque, NM (OIT), New Mexico -

- David Taylor, MHS, RPh, PA-C,RN, OIT EHR Training & Deployment Manager

- Jacque Candelaria, Albuquerque Area MU Coordinator & Co-HIM Consultant

- Phil Taylor, BA, RN, Clinical Consultant, Medsphere Systems Corporation

- Gail Townsend, OIT IT Specialist

- JoAnne Hawkins, Meaningful Use Team Lead, DNC (Contractor)

- James Garcia, PMP, MPI Manager, Office of Information Technology

3.2   Aberdeen Area Office, South Dakota -

- Leslye Rauth, MPH, RD, CDE, Aberdeen Area Clinical Applications Coordinator

- Tammy Brewer, CPC, Pine Ridge Comprehensive Health Care Center, HIM/Clinical Applications Coordinator

3.3   Alaska Native Tribal Health Consortium (ANTHC), Alaska

- Kimiko Gosney, MS, CC, ANTHC Clinical Applications Coordinator

- Maggie Lehn, RHIA, Alaska Area HIM Consultant, HIM Director for Samuel Simmonds Memorial Hospital (A)

3.4   Bemidji Area Office, Minnesota

- Teresa Chasteen, RHIT, Bemidji Area Clinical Applications Coordinator

- Barb Fairbanks, RHIT, Bemidji Area HIM Field Consultant

3.5   California Area Office, Sacramento -

- Steve Viramontes, RN, California Area Telemedicine Coordinator

- Marilyn Freeman, RHIA, California Area Clinical Application Coordinator

3.6   Nashville Area Office, Tennessee

- Robin Bartlett, PharmD, NCPS, Nashville Area Clinical Applications Coordinator

- Deborah Burkybile, MSN, RN, CPC, OIT & USET EHR Deployment Specialist

- Sheila Odom, Poarch Creek Health Department Clinical Applications Coordinator

- Chris Lamer, PharmD, MHS, BCPS, OIT Meaningful Use Federal Lead (A)

3.7   Navajo Area Office, Arizona -

- Beverly Becenti, RHIT, Navajo Area, HIM Consultant (A)

- Regina Yazzie, Gallup Indian Medical Center, Acting HIM Clinical Applications Coordinator

- Marcie Platero, RN, Gallup Indian Medical Center, Clinical Applications Coordinator

- Renetta Yellowhair - Francisco, Gallup Indian Medical Center, Acting HIM Supervisor

3.8   Oklahoma City Area Office, Oklahoma -

- Amy Rubin, PharmD, Oklahoma City Area Clinical Applications Coordinator

- Angela Kihega, RHIT, Oklahoma City Area HIM Consultant

- Peggy Shults, RHIA, Claremore Indian Hospital Assistant, HIM Director

- Tonya Billie, Clinton Indian Health Center, HIM Director

3.9   Phoenix Area Office, Arizona

- Elvira Mosely, MSHS, BSN, RN, Phoenix Area Clinical Applications Coordinator

- Kelly Stewart, MS, RHIA, IHS HIM Consultant (A)

- Maria Strom, RHIT, Phoenix Area HIM Informatics (Detail)

- Pat Gowan, MPA, RHIA, CPC, USET REC HIM Meaningful Use Consultant
- Kathy Nelson, CPC, Parker Indian Hospital HIM & Business Office

3.10   Portland Area Office, Oregon

- Cornelius Dial, BS, RPh, Portland Area Clinical Applications Coordinator
- Jamie Furniss, RHIT, CCS-P, Portland Area HIM Consultant
- Katie Johnson, PharmD, NWPIHB, EHR Integrated Care Coordinator

4.0   Detailed Agenda

All times are Mountain Time!

Monday		
Start	**Topic**	**TAB#**
1:00	Welcome & Introductions **All** At the end of this session participants should be able to: • Discuss & Review Training Materials • Identify Needs & Expectations • Demonstrate Ability to Access the RPMS EHR Training Database	
1:30	RPMS Orientation & Keyboarding Conventions **Betty Ruuttila** At the end of this session participants should be able to: • Navigate RPMS Menus & Apply Keyboarding Shortcuts • Personal Preferences • Recognize the List Manager View and How to Use it Efficiently • Discuss EHR, MU, Coding, VistA Imaging, & ICD-10 List-serv and the Process for Obtaining Technical Assistance • Identify Procedures Request Help and Submit Enhancement Requests (RPMS Feedback Page)	TAB 1
2:30	EHR & MU Scavenger Hunt (Eligible Professional) **All** At the end of this session participants should be able to: • Document MU Performance Measures within the Correct EHR Component • Identify Locations for Documenting Required MU Data Elements • Compare and Contrast Accessing Data using EHR vs. RPMS	TAB 2
3:30	Break	
3:45	Meaningful Use Overview for HIM Professionals **JoAnne Hawkins & Pat Gowan** At the end of this session participants should be able to: • Understand CMS EHR Incentive Program • Understand and Differentiate the Meaningful Use Performance Measures and the Meaningful Use Clinical Quality Measures • Review the current Meaningful Use Performance Measures as they Apply to HIM professionals	TAB 3
4:45	Wrap Up	
5:00	Adjourn	

Tuesday		
Start	**Topic**	**TAB#**
8:30	Clinical Summaries & Patient Reminders **Chris Lamer** At the end of this session participants should be able to: • Understand the Objective & the Measure • Examine the use of the Patient Wellness Handout (PWH) for Meeting this Measure • Print the Patient Wellness Handout Utilizing both the EHR GUI and RPMS Roll and Scroll • Compare and Contrast the Patient Wellness Handout Tally Report (PINT) & MU Performance Measures Report • Examine Policy and Guidelines for Clinical Summaries	TAB 4
9:30	Electronic Copy of Health Information **Barb Fairbanks & Angela Kihega** At the end of this session participants should be able to: • Understand the Objectives and the Measure • Identify Software Options for Creating PDF files • Identify Methods of Providing an Electronic Copy of Health Information • Create a PDF and Understand how to Disseminate Electronically • Record the Disclosure in the ROI package (request of electronic information & date electronic information was received) • Examine the use of the PHR for Meeting this Measure • Examine Policy and Procedures for Electronic Copy of Health Information	TAB 5
10:30	Break	
10:45	Electronic Exchange of Clinical Information (HIE, MPI & Patient Merge Overview) **Jamie Furniss, Cecelia Rosales & James Garcia** At the end of this session participants should be able to: • Understand the Objectives and the Measure • Comprehend the Different Components of HIE (HIE, MPI & C32) • Recognize the Necessary Sequence and Relationship of Patient Merge, MPI, C32 & HIE • Understand the Process and Purpose of Exchanging Patient Health Information with other I/T/U facilities and other Health Care Organizations	TAB 6
11:45	Lunch	

Tuesday		
Start	**Topic**	**TAB#**
1:00	Patient Electronic Access (Personal Health Record – PHR) **Kelly Stewart, Jamie Furniss & Maria Strom** At the end of this session participants should be able to: • Understand the Objectives and the Measure • Describe the Data Patients can Access • Examine the Privacy Policy, Terms & Conditions • Assess Applicable Policies and Procedures	TAB 7
2:00	Transition of Care Summary **Gail Townsend, James Garcia, Leslye Rauth & Tammy Brewer** At the end of this session participants should be able to: • Understand the Objectives and the Measure • Identify the Processes for RCIS Optimization • Illustrate the Benefits of Utilizing the RCIS package • Compare and Contrast RCIS vs. Consults • Print Summary of Care Utilizing the RCIS and C32 button • Examine Applicable Policies and Procedures	TAB 8
3:00	Break	
3:15	Medication List, Medication Allergy List, Patient Lists & Smoking Status **Toni Potts & Jamie Tapp** At the end of this session participants should be able to: • Understand the Objectives and the Measures • List the Options and Variations for Creating a Medication List • Describe the Components of the Medication List (Outpatient, Inpatient & Outside Meds) & Show How They Display in PCC • Describe the Process for Maintaining an Active Medication List • Generate the PLAL Report for the Purpose of Removing Allergies from the Problem List and Entering into the Adverse Reaction Tracking • List the Options for Creating Patient Lists (iCare, Diabetes Audit, Women's Health, Immunization, PGEN/VGEN, QMAN, CRS, etc) • Review the new PCC Health Factor Mnemonics to Capture Smoking Status	TAB 9

Tuesday		
Start	**Topic**	**TAB#**
4:00	Record Demographics & Advance Directives **Toni Potts** At the end of this session participants should be able to: • Understand the Objectives and the Measures • Record the Required Elements (Preferred Language, Race, Ethnicity, Record the Date & Preliminary Cause of Death) • Document Advance Directives in Both Patient Registration & Appropriate TIU Note Titles • Generate TIU/SSD List of Titles to verify Advance Directive is Associated with the Correct Title • Verify Scanned Advance Directive Documents are Associated with the Correct Note Title	TAB 10
4:45	Wrap Up	
5:00	Adjourn	

Wednesday		
Start	**Topic**	**TAB#**
8:30	Maintain Problem List **Maggie Lehn & Elvira Mosely** At the end of this session participants should be able to: • Understand the Objectives and the Measures • Generate a List of Uncoded Problems Utilizing the PCC/PRB "Fix Uncoded Problem File Diagnosis" • Assign the APCMZ PATIENT LIST Key to Generate a Patient list for MU Problem List Performance Measure • Generate a Patient List for Meaningful Use Problem List Performance Measure	TAB 11
9:00	Electronic Copy of Discharge Instructions **Kelly Stewart & Elvira Mosely** At the end of this session participants should be able to: • Understand the Objective and the Measure • Examine the use of the TIU Note Titles: Discharge Instructions, E-Copy Discharge Instr Not Received, E-Copy Discharge Instr Received • Generate TIU/SSD List of Titles to Verify that E copy was Received or **Not** Received • Appropriately Document within the ROI Package as Necessary	TAB 12

Wednesday		
Start	**Topic**	**TAB#**
10:00	Clinical Lab Test Results **JoAnne Hawkins, Andrea Scott, Clarence Smiley & Pat Gowan** At the end of this session participants should be able to: • Understand the Objective and the Measure • Compare and Contrast Laboratory Package, Reference Lab Interface, Point of Care lab & PCC Data Entry of Structured Laboratory Data • Discuss the Unintended Consequences of Entering Laboratory Results into PCC Data Entry in the Electronic Health Record Environment	TAB 13
10:30	Break	
10:45	Public Health Measures (Immunization Registries Data Submission, Syndromic Surveillance Data Submission & Reportable Lab Results to Public Health Agencies) **Kelly Stewart & JoAnne Hawkins** At the end of this session participants should be able to: • Understand the Objective and the Measure • Recognize Authorized Release and Use of Personal Health Information (PHI). • Review Required Data Use Agreements	TAB 14
11:15	Protect Electronic Health Information **Pat Gowan & Lisa Broome** At the end of this session participants will be able to: • Understand the Objective and the Measure • Review the Role of HIM in Conducting the Security Risk Analysis (Risk Management, Logical Access Control and Data Protection) • Examine Role Based Access as it Applies to the Electronic Health Record, HIPAA Privacy Rule, and Federal Information Security Management Act (FISMA)	TAB 15
11:45	Lunch	
1:00	PCC Coding Queue **Jamie Furniss** At the end of this session participants will be able to: • Understand Sorting Options within the Coding Queue • Manage Potential Merges through the Coding Queue • Manage the Coding Queue to Maintain Timely, Accurate, and Complete Health Records • Understand the RPMS Conventions and Commands for the Coding Queue • Update EHR Coding Audit Site Parameters • Auto-Complete Pharmacy Education Only Visits	TAB 16

Wednesday		
Start	**Topic**	**TAB#**
2:00	PCC Management & Error Reports **Pat Gowan & Amy Rubin** At the end of this session participants will be able to: • Manage Visits with a Zero Dependent Entry Count • Manage the Orphan Visits with No Primary Provider and/or POV • Manage the Data Transmission Transaction Errors • Manage the Inpatient Visit Review Report • Understand Other PCC Management Reports	TAB 17
3:00	Break	
3:15	Paperless Refill - Uncoded Diagnosis **Neill Dial, Elvira Mosely & Maria Strom** At the end of this session participants will be able to: • Review the Process for Paperless Refill from the Pharmacist's Perspective. • Compare and Contrast .9999 and 999.9 ICD-9 Codes as They Apply to Paperless Refill. • Fix UNCODED ICD9 Diagnoses for Paperless Refill • Review and Complete Paperless Refills Using the EHR Coding Queue by Clinic Code • Understand the Significance of 12:00 and 13:00 Pharmacy Visits. • Understand the Use and Sequencing of the V-Code and Diagnosis Code (POV)	TAB 18
3:45	Release of Information (ROI) **Barb Fairbanks** At the end of this session participants will be able to: • Add a New and Edit a Disclosure Record • Enter Disclosure Documentation • Compare and Contrast ROI Reports Used in Managing Release of Information • Discuss Significance of Documenting Electronic Requests and Releases • Manage Requesting and Receiving Parties	TAB 19
4:15	Sensitive Patient Tracking **Barb Fairbanks** At the end of this session participants will be able to: • Update Security Parameters to Track All Patients • Generate Sensitive Patient Tracking Reports by Patient, User, or Both • Enter/Edit Patient Security Level • List Sensitive Patients	TAB 20
4:45	Wrap Up	
5:00	Adjourn	

Thursday		
Start	**Topic**	**TAB#**
8:30	TIU Management - Notes **Maggie Lehn, Barb Fairbanks & Phil Taylor** At the end of this session participants should be able to: • Create a User Note Title Matrix for Managing Note Titles • Create and Inactivate a Note Title • Change or Rename a Note Title • Reassign a Note to the Correct Visit • Retract a Note • Monitor Late Entries • Review the Use of Addendums • Print Notes and other Patient Health Information • Compare and Contrast Proper Use of the "CWADF" • Correct Errors • Assign User Class • Configure Cosigners • Create and Manage Business Rules • Review Utilization of and Assign Surrogates • Compare and Contrast the Utilization of Cosigner versus Additional Signer • Create an Electronic Copy of Health Information	TAB 21
10:00	Break	
10:15	TIU Management - Templates **Toni Potts** At the end of this session participants should be able to: • Evaluate Accrediting Organizations Standards and ISO 9000 Requirements for Document Management • Discuss the Use of TIU Personal Templates	TAB 22
10:45	TIU Management - Reports **Peggy Shults** At the end of this session participants should be able to utilize the TIU Reports menu to: • Manage Unsigned and Un-cosigned Notes • Identify Missing Text & Clean up • Identify Reassignment of Documents • List Active Document Titles • Identify Reassigned Note Titles • Manage Electronically Filed Transcriptions	TAB 23

Thursday		
Start	**Topic**	**TAB#**
11:45	Lunch	
1:00	TIU Management – Reports (Continued) **Peggy Shults** At the end of this session participants should be able to utilize the TIU Reports menu to: • Manage Unsigned and Un-cosigned Notes • Identify Missing Text & Clean up • Identify Reassignment of Documents • List Active Document Titles • Identify Reassigned Note Titles • Manage Electronically Filed Transcriptions	TAB 23
2:00	CPRS - Reports and Nature of Order **Tonya Billie** At the end of this session participants should be able to: • Generate Unsigned Orders Search • Discuss the HIM Role in Searching for Unsigned Orders. • Compare and Contrast the use of Written, Policy, Verbal, and Telephone "Nature of Order".	TAB 24
2:30	Break	
2:45	Personal Health Record (PHR) **Chris Lamer & Jamie Furniss** At the end of this session participants should be able to: • Understand Purpose and Importance of PHR in the Indian Health Care System • Examine the role of HIM in Registrar Functions • View a Demonstration of PHR • Summarize PHR Dependencies on other RPMS Applications.	TAB 25
3:45	Patient Merge **Anne Spencer & Tonya Billie** At the end of this session participants should be able to: • Recognize the Necessary Sequence and Relationship of MPI, C32, and HIE • Delineate Steps for Printing a List of Potential Merges • Verify Potential Duplicates • Merge Valid Duplicates • UNDERSTAND THAT THERE IS NO UNMERGE!!! • How and where to sign up for Required User Training	TAB 26
4:45	Wrap-up	
5:00	Adjourn	

Friday		
Start	**Topic**	**TAB#**
8:30	Patient Flags **Kelly Stewart & Jamie Furniss** At the end of this session participants should be able to: • Compare and Contrast the Use of Patient Flags • Examine Policy and Guidelines for Patient Flags • Identify HIM Roles and Responsibilities for Management of Patient Flags • Create a Patient Flag • Generate Reports for Managing Patient Flags	TAB 27
9:30	Alerts & Notification Management **Tonya Billie & Amy Rubin** At the end of this session participants should be able to: • Compare and Contrast Alerts and Notifications • Generate VUA Lists to Manage Users Notifications • Schedule Notifications • Erase Notifications • Review the Utilization of Alert Management Menus	TAB 28
10:15	Break	
10:30	VistA Imaging **Jamie Furniss** At the end of this session participants should be able to: • Examine Policy and Guidelines for Vista Imaging • Review Processes for Scanning Documents • Perform Quality Checks and Correct Errors	TAB 29
11:45	Lunch	
1:00	Pick Lists **Jamie Furniss** At the end of this session participants should be able to: • Create and Maintain Diagnostic Pick Lists • Create and Maintain Procedural Pick Lists • Assign Associations to Procedural Pick Lists	TAB 30
1:45	ICD-10 **Janice Chase** At the end of this session participants should be able to: • Understand the Creation and History of ICD-10-CM and ICD-10 PCS • Understand the Impact of ICD-10 on Current Processes • Discuss Plan for Implementation of ICD-10 Throughout Indian Health System	TAB 31

Friday		
Start	**Topic**	**TAB#**
2:45	Break	
3:00	C32 **James Garcia** At the end of this session participants should be able to: • Understand the Purpose and Uses of the C32 Continuity of Care Document (CCD) • Examine Role-Based Access for C32	TAB 32
4:00	Meaningful Use Reports **Barb Fairbanks, Teresa Chasteen & Cecilia Rosales** At the end of this session participants should be able to: • Generate & Review MU Performance Measure Report • Generate & Review Clinical Quality Measure Report • Generate a Patient List through the Performance Measure Report	TAB 33
4:45	Survey Monkey Evaluation and AACP Continuing Education Certificate	

5.0   ARRA, HITECH, and Meaningful Use

Background

On February 17, 2009, President Barack H. Obama signed the ARRA into law. ARRA provides incentives to encourage hospitals and office-based physicians to adopt EHRs and other health information technology (HIT) solutions that reduce costs by improving quality, safety, and efficiency. ARRA contains numerous technology and privacy provisions with aggressive timelines for completion. Many of these ARRA milestones relate to the standards and work of the Healthcare Information Technology Standards Panel.

Health Information Technology for Economic and Clinical Health Act

The Health Information Technology for Economic and Clinical Health Act (HITECH) is a focal point of ARRA and represents an investment of more than $19 billion towards healthcare information technology (IT)-related initiatives. The $19 billion dedicated to HITECH is divided into two portions: (a) $17 billion toward a Medicare/Medicaid incentive reimbursement program for both healthcare organizations and providers who can demonstrate "meaningful use" of an approved EHR; and (b) $2 billion available to providers located in qualifying rural areas, providers serving underserved urban communities, and providers serving underserved Indian tribes. Meaningful use of an approved EHR is required in order for providers to qualify for, and continue to receive, incentives.

Incentive Payments

ARRA will provide incentive payments through Medicare and Medicaid reimbursement systems to encourage providers and hospitals to adopt EHRs and HIT. Incentive payments are triggered when a provider or hospital demonstrates that it has become a "meaningful EHR user." The highest incentive payments will be granted to hospitals that adopt EHR technology in the years 2011, 2012, or 2013. Reduced incentive payments are granted to hospitals that adopt EHR technology in the years 2014 or 2015, while no incentive payments are granted to hospitals that adopt EHR technology after 2015. Providers and hospitals that fail to meet this time limit will be subject to penalties in the form of reduced Medicare reimbursement payments beginning in 2017.

Meaningful Use

Meaningful use is a term used by the Centers for Medicare and Medicaid Services (CMS) to ensure that providers and hospitals that have adopted certified EHR are using the technology to further the goals of information exchange among health care professionals. EPs (eligible providers) and EHs (eligible hospitals) will achieve meaningful use if they: (a) demonstrate use of certified EHR technology in a meaningful manner, (b) demonstrate the certified EHR technology provides for electronic exchange of health information to improve quality of care, and (c) use certified EHR technology to submit information on clinical quality and other measures.

Achieving meaningful use will be accomplished in three stages. Stage 1 will begin in 2011, Stage 2 will begin in 2013, and Stage 3 will begin in 2015. The criteria for achieving meaningful use will increase with each stage and will build upon the prior stage. Medicare and/or Medicaid incentives are available to providers and hospitals who become meaningful users of certified EHR technology, with the maximum incentives being given to EPs and hospitals that become meaningful users in Stage 1. Hospitals may be eligible for both Medicare and Medicaid incentives but EPs must choose between the two incentive programs.

In order to achieve Meaningful Use, an EP must report on 15 core performance measures and 5 out of 10 menu set performance measures simultaneously. One of the EP's chosen menu set measures must be a designated Public Health Objective. Eligible hospitals must report on 14 core performance measures and 5 out of 10 menu set performance measures simultaneously. One of the selected menu set performance measures must be a designated Public Health Objective.

For demonstrating Meaningful Use through the Medicare EHR Incentive Program, the reporting period for the first year is any continuous 90-day period. In subsequent years, the EHR reporting period is the entire year. Under the Medicaid program, performance measures and incentive payments may be awarded for merely adopting, implementing or upgrading certified EHR technology. Consequently, there is no Medicaid reporting period for year one – all subsequent reporting periods are a full year.

Meaningful Use Standards and Measures

As required to achieve MU, eligible hospitals and EPs must report their performance on two types of measures:

- Performance Measures
- Clinical Quality Measures

The performance measures aim to improve quality, safety, efficiency and reduce health disparities. There are two types of performance measures: 1) Rate measures are numerically calculated with numerator and denominator data, 2) Attestation measures must be answered with a yes or no question.

Table 1: Summary Overview of Meaningful Use Core Set Measures

Short Name	Objective:	Measure:
Demographics	Record demographics: preferred language, gender, race and ethnicity, date of birth, and date of death and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	More than 50% of all unique patients seen by the EP or admitted to the eligible hospitals or CAH's inpatient or emergency departments (POS 21 or 23) have demographics recorded as structured data. (*EPs, EHs & CAHs*)
Vital signs	Record and chart changes in the following vital signs: Height, weight and blood pressure and calculate and display body mass index (BMI) for ages 2 and over, plot and display growth charts for children 2-20 years, including BMI.	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23), height, weight, and blood pressure are recorded as structured data. (*EPs, EHs & CAHs*)
Problem List	Maintain up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data. (*EPs, EHs & CAHs*)
Medication List	Maintain active medication list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. (*EPs, EHs & CAHs*)

Short Name	Objective:	Measure:
Medication Allergy List	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. (*EPs, EHs & CAHs*)
Smoking Status	Record smoking status for patients age 13 or older.	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have smoking status recorded as structured data. (*EPs, EHs & CAHs*)
Clinical Summaries	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. (*EPs Only*)
Electronic Copy of Health Information	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request.	More than 50% of all patients seen by the EP or of the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days. (*EPs, EHs & CAHs*)
ePrescribing	Generate and transmit permissible prescriptions electronically.	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. (*EPs Only*)

Short Name	Objective:	Measure:
CPOE Medication	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE. NOTE: In Stage 2, the measure target increases to 60%. (*EPs, EHs & CAHs*)
Drug-Drug & Drug-Allergy Checks	Implement drug-drug and drug-allergy interaction checks.	Functionality is enabled for these checks for the entire reporting period. (*EPs, EHs & CAHs*)
Clinical Decision Support	For EPs, implement one clinical decision support rule relevant to specialty or high clinical priority. For eligible hospital or CAH implement one related to a high priority hospital condition along with the ability to track compliance with that rule.	Implement one clinical decision support rule. (*EPs, EHs & CAHs*)
Privacy/Security	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) of the certified EHR technology, and implement security updates and correct identified security deficiencies as part of its risk management process. (*EPs, EHs & CAHs*)
CQM	Report ambulatory and hospital clinical quality measures to CMS or, in the case of Medicaid, to the States.	Successfully report to CMS (or, in the case of Medicaid, to the States) ambulatory and hospital clinical quality measures selected by CMS in the manner specified by. (*EPs, EHs & CAHs*)

Short Name	Objective:	Measure:
Exchange of Key Clinical Information	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient's authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. (*EPs, EHs & CAHs*)
Electronic Copy of Discharge Instructions	Provide patients with an electronic copy of their discharge instructions at the time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it. (*Hospitals Only*)

Table 2: Summary Overview of Menu Set Meaningful Use Measures

Short Name	Objective:	Measure:
Drug-Formulary Checks	Implement drug formulary checks.	The EP, eligible hospital/CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. (*EPs, EHs & CAHs*)
Lab Results into EHR	Incorporate clinical laboratory test results in EHRs as structured data.	More than 40% of all clinical lab test results ordered by an EP or authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency departments (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. (*EPs, EHs & CAHs*)
Patient List	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition. (*EPs, EHs & CAHs*)

Short Name	Objective:	Measure:
Patient-Specific Education	Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate.	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources. (*EPs, EHs & CAHs*)
Medication Reconciliation	The EP, EH or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23). *EPs, EHs & CAHs*)
Summary of Care	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The EP, EH or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals. (*EPs, EHs & CAHs*)
Advance Directives	Record advance directives for patients 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded as structured data. (*Hospitals Only*)
*Immunization Registries	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the EP, EH or CAH submits such information have the capacity to receive the information electronically.) (*EPs, EHs & CAHs*)

Short Name	Objective:	Measure:
Patient Reminders	Send reminders to patients per patient preference for preventive/follow-up care.	More than 20% of all unique patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. (*EPs Only*)
Timely Electronic Access to Health Information	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four (4) business days of the information being available to the EP.	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four (4) business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. (*EPs Only*)
*Submit Lab Results to Public Health Agencies	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically.) (*Hospitals Only*)
*Syndromic Surveillance	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Perform at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which EP, EH or CAH submits such information have the capacity to receive the information electronically.). (*EPs, EHs & CAHs*)
* All EPs, EHs and CAHs must choose at least one of these populations and public health measures to demonstrate as part of the menu sets.		

6.0   Biographical Sketches

The Indian Health Service (IHS) Office of Information Technology (OIT) National Electronic Health Record (EHR) Training and Deployment Program and Health Information Management (HIM) Consultants workgroup worked diligently to prepare the necessary deployment and training documents to facilitate the deployment of the Meaningful Use (MU) of an EHR. We hope that you find both the training and training documents helpful.

The Office of Information Technology conveys its sincere thanks to all the members and guests of this workgroup. They spent long hours preparing and updating these documents and even longer documenting their experience; they deserve our appreciation. Without these dedicated workgroup members this "EHR & MU for Health Information Management" hands-on course would not be possible.

LCDR Mollie Ayala, MHI
OIT USET EHR Training and Deployment Coordinator

LCDR Robin A. Bartlett, PharmD, NCPS
Nashville Area Clinical Applications Coordinator / Pharmacy Consultant
>LCDR Robin Bartlett is currently serving Nashville Area Clinical Applications Coordinator and Chief Pharmacy Area Consultant as of April 2010. LCDR Robin Bartlett previously served as Cherokee Indian Hospital Clinical Applications Coordinator from 2006 to April 2010. Cherokee Indian Hospital has been utilizing the outpatient Indian Health Service Electronic Health Record (EHR) since 2004, implemented EHR on their inpatient ward in 2007, implemented inpatient Bar Code Medication Administration (BCMA) in 2008, and is currently in the process of implementing EHR in the Emergency Department. LCDR Robin Bartlett served an integral role in assisting with analysis of flow process, identification of opportunities for improvement, coordination with clinical department supervisors, plan development, clinical staff training, and implementation of new processes and clinical applications to improve patient care and documentation at Cherokee Indian Hospital. LCDR Bartlett is a Commissioned Officer in the USPHS and has been in the Indian Health Service since 2001. After graduating with a Doctor of Pharmacy degree from University of Florida, LCDR Bartlett completed a one-year Indian Health Service Pharmacy Practice Residency Program at Cherokee Indian Hospital. LCDR Bartlett transferred to Whiteriver Indian Hospital in 2002 and served the role of a Clinical Staff Pharmacist, Vaccines for Children Immunization Coordinator, and PCC+ Implementation Pharmacy Team Lead. LCDR Bartlett transferred back to Cherokee Indian Hospital in 2004 and served as a Clinical Staff Pharmacist, Pharmacy Intern Experiential Program Director, Inpatient Pharmacy Services Coordinator, Joint Commission Medication Management Workgroup Team Leader, and electronic MAR Implementation

Project Manager. LCDR Bartlett is certified as a National Clinical Pharmacy Specialist (NCPS) in Anticoagulation through the IHS Clinical Support Center and is certified as an adult pharmacy-based immunization provider. LCDR Robin Bartlett is currently enrolled in a Masters in Science of Pharmacy degree program with special emphasis in Patient Safety and Risk Management from the University of Florida.

Tonya Billie
Clinton Service Unit Medical Records Administrator

Ms. Billie has 16 years of HIM experience, 15 of which have been in the private sector in non-profit and profit facilities. A majority of her experience has been in the inpatient setting of specialty and Trauma One facilities. She currently serves as the HIM Director of the Clinton Service Unit.

Tammy Brewer, CPC
Pine Ridge Service Unit, Supervisory Medical Records

Tammy is member of the Oglala Sioux Tribe and has worked at Pine Ridge Indian Health Service for 20 years in the Medical Records Dept. She started out in Coding/Data Entry, working her way up In 2001 she became a certified coder and a member of AAPC. She graduated from Oglala Lakota College with an AAS in Management Information Systems. While at I.H.S she has served on numerous teams including the E.H.R. Team. She is currently working toward her certification in Health Information Technology.

CAPT Deborah Burkybile, RN, MSN, CPC
OIT USET EHR Training/Deployment Consultant

Deborah has been a Registered Nurse for 30 years. During this time her nursing practice led her to work in a variety of private sector hospitals, clinics, tribal facilities, and for the last 22 years in Indian Health Service. CAPT Burkybile has been on assignment to OIT since 2005 as the National EHR Training/Deployment Consultant and has worked diligently to train and deploy the IHS RPMS EHR across the nation in federal, tribal, and urban health facilities. Deborah is a citizen of the Cherokee Nation of Oklahoma. She received her Commission in the U.S. Public Health Service in 1988 and presently works from the Nashville Area Office. Deborah has functioned in a number of nursing practice roles including Community Health, Addictions, Injury Prevention, and Managed Care. She is also a Certified Professional Coder. Deborah is strongly committed to improved patient through the use of the IHS EHR and has found her assignment to OIT to be one of the most satisfying nursing experiences to date.

Teresa Chasteen, RHIT
Bemidji Area Clinical Applications Coordinator

Teresa is the Bemidji Area Clinical Applications Coordinator. Her previous position at the Cass Lake Indian Health Service was the Director of Health Information, where she was the Project Lead for EHR Implementation. She

served as one of the Bemidji Area Health Information Management Consultants. She started her Health Information Management career in 1984 and has been in the health care field since 1980. Teresa has worked in Indian Health Service since 1996. She obtained the Registered Health Information Technician (RHIT) in 1992 from the College of Saint Catherine Saint Mary's campus.

CDR Cornelius ("Neill") Dial, RPh
Portland Area Area Clinical Applications Coordinator

In his 16 years working for the Indian Health Service, CDR Dial has served at the Clinic, Service Unit and Area level. He started his IHS career as a COSTEP at the Ft. Thompson Health Center on the Crow Creek reservation in the Aberdeen Area, served in the Albuquerque Area and later at the Navajo Area's Gallup Indian Medical Center as the Pharmacy Clinical Applications Coordinator / Pharmacy Package Administrator.   He is the Vice Chair of the Pharmacy Specialty Group Committee, serves on the IHS National P&T Committee and the National Pharmacy Council. CDR Dial hails from North Carolina and is a graduate of the University of North Carolina – Chapel Hill.

Barb Fairbanks, RHIT

Vicki French

Jamie Furniss, RHIT, CCS-P
Portland Area HIM Consultant

Ms. Furniss has worked for the Indian Health Services in Fort Hall, Idaho for 12 years, primarily in Health Information Management (HIM). She has also served as the Clinical Applications Coordinator (CAC) at Fort Hall for 3 years and as the Portland Area HIM Consultant for 1 year

Pat Gowan, MPA, RHIA, CPC
United South and Eastern Tribes (USET) EHR HIM & MU Consultant

Patricia A. Gowan is a Registered Health Information Administrator (RHIA) and a Certified Professional Coder (CPC). Currently, she is the Indian Health Service Lead Health Information Management (HIM) Consultant as well as the HIM Consultant for the Phoenix Area. Past experiences include Director, Health Information Management, Whiteriver Service Unit and Assistant Director, Health Information Management, Phoenix Indian Medical Center. She earned her undergraduate degree in Health Information Management from Carroll College, Helena, Montana, and a graduate degree in Public Administration from Northern Arizona University, Flagstaff, Arizona. She is a member of the American Health Information Management Association (AHIMA), Arizona Health Information Management Association of Arizona (AzHIMA) and American Academy of Professional Coders (AAPC)

JoAnne Hawkins, Meaningful Use Lead
DNC Contractor

Currently serves as a contractor with Data Network Corporations. JoAnne is the Team Lead for 15 Meaningful Use Field Consultants. She has over 13 years of training experience in various industries including healthcare. Her focus is to help Indian Country achieve Meaningful Use.

Angela Kihega, RHIT
Oklahoma Area HIM Consultant

CDR Christopher Lamer, PharmD, BCPS, CDE NCPS
OIT Informatics Consultant

CDR Christopher Lamer is a Commissioned Officer in the United States Public Health Service and has been in the Indian Health Service since 1998. CDR Lamer is a pharmacist and works as a clinical informaticist for the Office of Information Technology and Health Education. CDR Lamer participates in the development of clinical programs, quality metrics, and support of RPMS applications. CDR Lamer is a Management analyst for OIT, Federal lead for PHR and EHR Certification.

Maggie Lehn, RHIA
Alaska Area HIM Consultant (A)

Ms. Lehn currently serves as the HIM consultant for the Alaska Area. She is the Manager of Health Information at Samuel Simmonds Memorial Hospital in Barrow and has served as a co-CAC and EHR Coordinator. She has worked with the RPMS system for the last 6 years in Barrow and is familiar with several packages. Her previous experience includes teaching a Health Information Technology Program in Minnesota for 10 years, as well as teaching some classes at Illsavik College in Barrow, Alaska.

Jason Loepp

CAPT Elvira Mosely, MSHS, RN
Phoenix Area Clinical Applications Coordinator

CDR Elvira Mosely, RN, is the Clinical Program Consultant for the Electronic Health Records (EHR) for Phoenix Area Indian Health Service. She received her BSN degree in 1988 from Jacksonville University in Jacksonville Florida and received her MSHS degree in 2006 from Touro University California. She worked as the Clinical Application Coordinator for the Hopi Health Care Center for one year before she applied and was accepted to be the Clinical Program Consultant for the Phoenix Area Indian Health Services on June 2006. Prior to this, she served for the US Air Force on active duty status for 11 years serving in a wide range of nursing positions. In 2004 she transferred to the US Public Health Service and is presently on Active Duty status assigned to Phoenix Area Office. Elvira has been the lead project manager for the

implementation and coordination of the RPMS EHR for all Phoenix Area Indian
Health Services since June 2006

Sheila Odom
Poarch Creek Health Department Clinical Applications Coordinator

Ms. Odom has been with the Poarch Creek Health Department for twenty four years,
the last fifteen which have been in the position of the Health Systems Technician; and
then later as the Clinical Application Coordinator.

Toni Potts, Clinical Applications Coordinator-Manager Cherokee Nation,
Tahlequah, Oklahoma

Ms. Potts served as Clinical Applications Coordinator since 2004, when W.W.
Hastings Indian Hospital was a Beta Test Site for IHS-EHR. She is responsible for
configure, maintain, support, and providing training for the Electronic Health Record
and many other RPMS applications on a daily basis. Ms. Potts is currently the
Manager of the Cherokee Nation Health Services CAC Team.

CDR Amy Rubin, PharmD
Oklahoma City Area Office Clinical Applications Coordinator

CDR Amy Rubin began her career with the Commissioned Corps and the Indian
Health Service in 1999 as an Assistant Chief Pharmacist in a small clinic. In 2002,
she transferred to a hospital as a clinical pharmacist and soon moved into the
Assistant Chief Pharmacist position. During this tenure, CDR Rubin was actively
involved in many aspects of the operations of the hospital and was actively involved
in many committees. She took on the task of preparing and coordinating the
pharmacy for the conversion to Pharmacy 5/7 software. She also assisted in the
design and set-up of the new ambulatory care clinic including working with
architectures and Information Technology staff to develop a facility with the ability to
support successful implementation of the RPMS Electronic Health Record
(RPMSEHR). Both of these activities led to the assignment as Acting Clinical
Applications Coordinator (CAC) in November 2007 to lead the process of
implementing RPMS EHR throughout the service unit (3 facilities). She remained the
Assistant Chief Pharmacist during this initial phases of implementation and
performed in both capacities. In May 2008, she was selected as the full-time Service
Unit CAC. The Service Unit under her leadership was successful in implementing
RPMS/EHR at 3 facilities. In April 2009, CDR Rubin made the transition to the
Oklahoma City Area CAC. In this capacity, she provides EHR support to all sites
using EHR in the Oklahoma City Area. She is actively involved in the
implementation of new sites. Additional duties include serving as the Meaningful Use
Coordinator for the Area and supporting the Area Improving Patient Care Iniatitive.
She will complete a Masters in Medical Informatics in December 2011.

LCDR Andrea Scott, MBA, BS
Navajo Area Clinical Applications Coordinator

LCDR Andrea Scott is currently serving as the Navajo Area Clinical Applications Coordinator and Navajo Area Meaningful Use Coordinator and supports eight federal/tribal service units in deploying EHR for the Indian Health Service Navajo Area at the Navajo Area Office (NAO) in Window Rock, AZ. LCDR Scott has an MBA degree in Health Care Management from Western International University in Phoenix, Arizona and a BS degree in Microbiology from the University of Arizona in Tucson, Arizona. The first 15 years of LCDR Andrea Scott's civil service career with the Indian Health Service entailed positions held as a Microbiologist, Medical Technologist Generalist, Laboratory Application Coordinator, Phoenix Area Clinical Applications Coordinator, and Medical Staff Office Coordinator. LCDR Andrea Scott served in these roles at the following Indian Health Service Facilities: Phoenix Indian Medical Center, Tsaile Health Center, Chinle Service Unit, and Shiprock Service Unit. She was also employed for the VA Medical Center in Phoenix, Arizona as a Medical Technologist. LCDR Andrea Scott received her commission in the U.S. Public Health Service in 2006 and has since served at the Shiprock Service Unit as the Clinical Applications Coordinator, Phoenix Indian Medical Center as the Clinical Applications Coordinator and Immunizations Applications Coordinator, and at Crownpoint Service Unit as the Acting Laboratory Supervisor upon receiving her commission.

Anne Spencer, RHIT
Albuquerque Area HIM Consultant

Ms. Spencer has been employed with IHS for 23 years and is currently the HIM Manager at the Albuquerque IHS Dental Clinic. Anne started serving as the HIM consultant for the Albuquerque area in February 2009. Anne received her education through the UNM-Gallup and San Juan College in Farmington, NM. Anne is currently a member with AHIMA as a Registered Health Information Technician.

Kelly Stewart, MS, RHIA
IHS & Phoenix Area HIM Consultant (A)

Ms. Stewart has been an HIM Director for over 10 years in a variety of facilities. While with the State of Colorado, she served as the Information System Project Coordinator involved with the analysis, design and development of a new computer system. She also helped with Implementation and training as on-going training for almost 3 years. She currently serves on the PIMC EHR team as well as conducted initial trainings for all EHR users.

CAPT (ret) David R. Taylor, MHS, RPh, PA-C, RN, NCPS
EHR Training and Deployment Manager
IHS Office of Information Technology

CAPT (ret) David Taylor is a retired Commissioned Officer in the United States Public Health Service and is a certified physician assistant, registered pharmacist, and registered nurse. Captain (ret) Taylor holds more than 33 years of public health, clinical, and clinic-administrative experience in the Indian Health Service (IHS). During his commission, he has served as a pharmacist, physician assistant, quality manger, risk manager, and compliance officer for the Pine Ridge, South Dakota and Cherokee, North Carolina Indian Hospitals. He has also served as an HIV/AIDS/STD consultant, performance improvement consultant, pharmacy consultant, and diabetes clinical consultant for the Nashville Area Indian Health Service. At this time, he is the EHR Deployment Manager for the IHS Office of Information Technology and has been charged with both training and deployment of the Electronic Health Record throughout the entire Indian Health Care system. David Taylor has been awarded the PHS Meritorious Service Medal (MSM) in recognition for his accomplishments in the EHR arena.

Phil Taylor, BA, RN
Clinical Application Specialist, Medsphere Corporation

Phil is a Clinical Consultant for Medsphere Systems Corporation. Phil has been a Registered Nurse for 34 years. He holds a degree in Nursing from Vincennes University and a B.A. in Classical Studies from Indiana University. Phil practiced as a staff nurse or nurse manager in Psychiatry for over 15 years. Phil provided clinical application support to VA Medical center staff in Indianapolis using the VistA electronic medical record system for over 12 years prior to joining Medsphere. Since joining Medsphere, Phil has worked with the national IHS deployment team for the past 5 years providing training support (such as Basic CAC School and EHR for Inpatient) and configuration/setup support to RPMS-EHR installations.